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ABSTRACT

An invitational conference brought experts and concerned, active individuals together to review and identify research and program needs for rural Texas health care. The goals of the conference were to prioritize the top five program and research activities for rural health care in the 1980's, to develop a network of communication and cooperation among individuals and groups with complimentary interests in Texas rural health care, and to develop a plan of action for the identified program and research priorities. The selected priorities included creation of a State Office of Rural Health, increase in the number of rural health personnel, expansion of the legal functions of nurse practitioners, identification of unmet health needs, evaluation of county service delivery systems, and identification and description of innovative community problem solving efforts. The first section of the conference report discusses the method used by conference facilitators to identify program and research priorities. The second section, consisting of program research priorities, provides a detailed description of the results of the planning sessions. The third section reports the participant's evaluation of the conference, and the final section summarizes conference findings and delineates future directions. Appendices include a directory of conference participants and the guide for conference facilitators. (JH)

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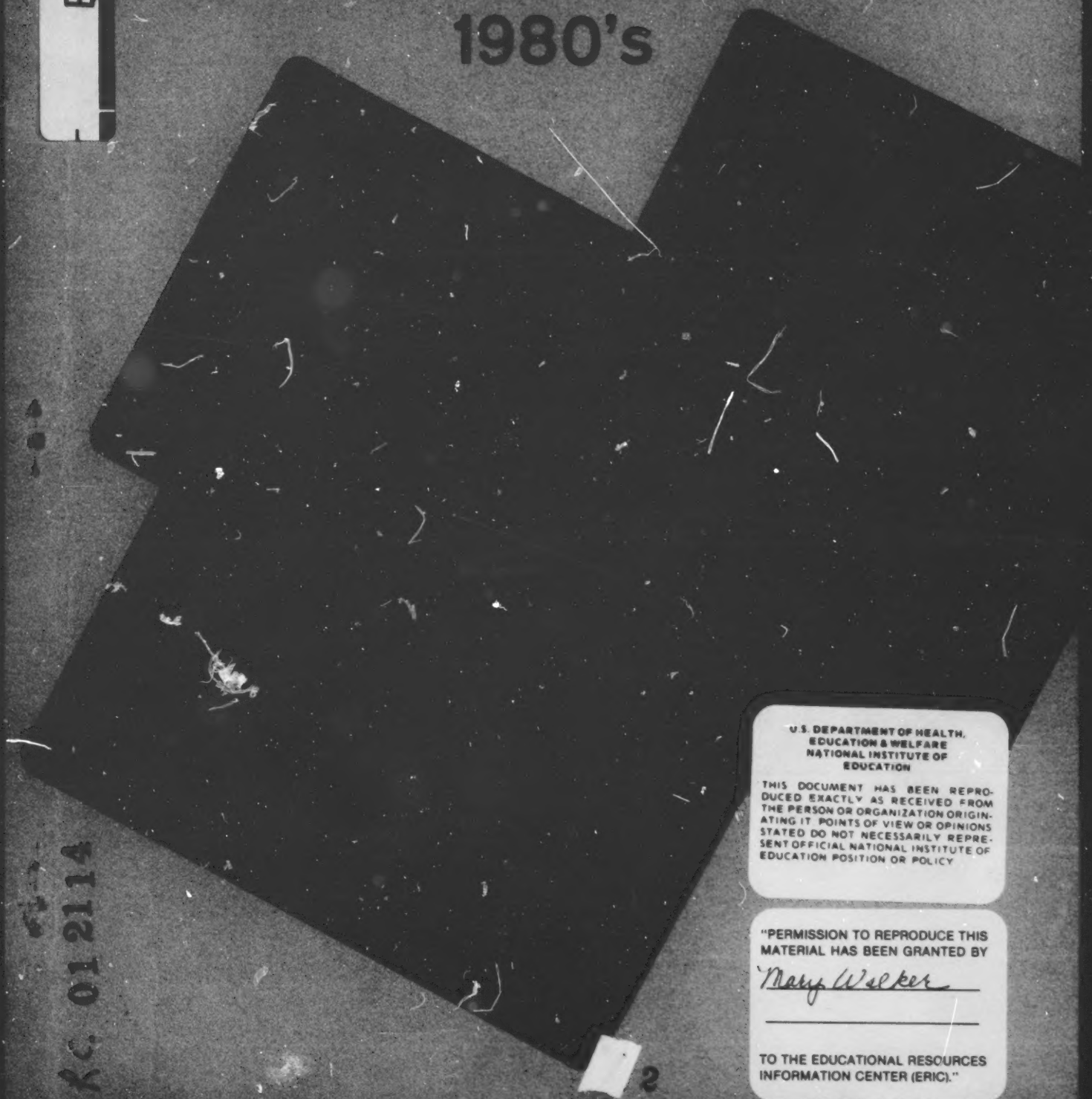
TEXAS RURAL HEALTH PROGRAM & RESEARCH PRIORITIES FOR THE 1980's



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Texas Rural Health Care Program and

Research Priorities for the 1980's

Report of a conference sponsored by the Texas Rural Health Field Services Program on April 18, 1980 in Austin, Texas.

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Table of Contents

Introduction 1

Method 4

Program and Research Priorities in Texas Rural Health Care for the 1980's 7

Program Priorities 7

Research Priorities 15

Conference Evaluation 20

Conclusion and Future Directions 22

Appendices 24

INTRODUCTION

After a decade of decreasing, the population of rural Texas increased by more than 6% in the 1970's. This increase is expected to accelerate as we move into the 1980's, further compounding the problem of providing health care to rural Texans.

There exists in the minds of urban Texans the myth that rural Texans enjoy universally good health, despite evidence to the contrary. Statistics show that accidents and suicides are higher in rural areas than in urban areas. Rural residents experience more chronic illness and more days of disability than their urban conterparts. Rural living produces drug abuse, child abuse, battered wives, depression and teenage pregnancies just as frequently as urban living. In addition, rural Texans are less educated, poorer and die at an earlier age than urban Texans. Rural areas have substandard housing, poor communication and transportation systems, and inadequate sewage and water systems.

Much progress has been made in the provision of health care to Texans. This progress, however, has been confined primarily to urban Texans; bypassing the state's rural residents. The health care problems in rural Texas have remained much the same for decades. Among these problems are:

1. Limited access to health services, particularly primary care services.
2. Limited availability of health services, especially emergency and preventive services.
3. Lack of health manpower - not only primary care physiciars, but also nurse practitioners, dentists, psychologists, social

workers, pharmacists and others.

4. Laws, regulations and practices which place constraints upon the development of innovative solutions to rural health problems.
5. Lack of a coherent state health policy and rural health policy.

Rather than belabor the point that these issues exist and are adversely affecting the lives of rural residents, an invitational conference was held on April 18, 1980 to explore ways of alleviating these problems. The conference entitled "Texas Rural Health Program and Research Priorities for the 1980's" was sponsored by the Texas Rural Health Field Services Program.

The conference took a social planning approach, whereby experts and concerned active individuals were brought together to select, prioritize and review research and program needs for rural Texas health care. The goals of the conference were to:

1. Identify and prioritize the top five program and research activities for Texas rural health care in the 1980's.
2. Develop a network of communication and cooperation between individuals and groups with complimentary interests related to Texas rural health care.
3. Develop a plan of action for the identified program and research priorities.

The following report first discusses the method which was utilized throughout the conference to identify the top five program and research priorities in Texas rural health care. The second section, consisting

of two parts, program priorities and research priorities, provides a detailed description of the results of the planning sessions. In the third section, the participant's evaluation of the conference is reported. The last section summarizes the conference findings and delineates future directions.

METHOD

Eighty individuals representing academic institutions, Health System Agencies, health facilities, state agencies, legal services, and rural organizations such as the Farm Bureau and Texas Electrical Co-ops were invited to participate in the conference. (Appendix A) The initial mailout included an introductory, invitational letter, and a survey form. (Appendix B) Respondents were requested to list the top five priorities in program and research for Texas rural health care in the 1980's. The survey form, of the Delphi type, was designed in such a way that each respondent had complete freedom in his/her reaction.

It was the intention of the planning committee* to catagorize and screen the initial responses and prepare a second mailout of the top ten responses for programs and for research. All respondents were to be asked to select the top five program and research priorities from these ten before the conference date. This did not occur due to the slow return of the survey forms by the conference participants. Therefore, we entered into the conference with a list of 64 program priorities (Appendix C) and 101 research priorities (Appendix D).

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*Members of the planning committee were: Donnie Robinson-Caire, Conference Coordinator and Research Associate, Texas Rural Health Field Services Program; Mary Walker, R.N., Ph.D. Program Director, Texas Rural Health Field Services Program; Jim Burdine, Dr. P.H., Assistant Professor and Coordinator of Community Health, U.T. Dept. of Health and Physical Education; Jan Ice, Graduate Student, Programming Community Health, U.T. Dept. of Health and Physical Education; Sherry Bell, Graduate Student, Programming Community Health, U.T. Dept. of Health and Physical Education; and Alma Hunsicker, Program Secretary, Texas Rural Health Field Services Program.

The conference day was divided into two segments, one for programs and one for research. The initial forty minutes of each segment was spent in four small group sessions. Conference participants were randomly assigned to Groups A, B, C, or D according to their arrival and registration time. A member of the conference planning committee served as a facilitator for each group. (Appendix E)

During the first twenty minutes of the small group sessions, the participants reviewed the lists of program priority survey responses (Appendix C) and research priority survey responses (Appendix D). Each participant then selected what they considered to be the top five priorities ranking them from 1 to 5, with one being the most important and five the least important. During this initial step, no discussion was allowed. The next twenty minutes were devoted to developing consensus on the top priorities within each small group. Each individual reported their choices to the group facilitator. Points were assigned in decreasing order, with five points for the first priority of each individual, through one point for each individual's fifth priority. The priority with the highest total point score was the group's first priority. At the end of this process, all four small groups came together and the group facilitators reported the five priorities selected by their group to the large group. Once this reporting was completed and all duplications had been eliminated, the conference participants were asked to select and prioritize the top five program and research items from those identified by the small group.

Each individual reported their choices. The same point system used in the small group prioritization was used in recording the priorities identified in the large group. The results of this voting were the

top five program and top five research priorities for Texas rural health care in the 1980's.

The last hour of the morning and afternoon segments was spent in two larger planning groups. Small groups A and B combined to form Planning Group I, and Small Groups C and D formed Planning Group II. In these planning groups, the conference participants examined current and proposed actions, potential leaders, available resources and obstacles to implementing the program and research priorities.

During the morning segment all five program priorities were discussed. Planning Group I was responsible for answering questions regarding priorities one, three and five. Planning Group II was responsible for answering the same questions for one, two and four. During the afternoon segment, a shortage of time permitted examination of only the top two research priorities. Planning Group I dealt with priority one and Planning Group II dealt with priority two.

The next section presents the top five program and research priorities. The priorities are followed by a summarization of the planning groups discussion.

PROGRAM AND RESEARCH PRIORITIES IN

TEXAS RURAL HEALTH CARE FOR THE 1980's

This section presents the results of the planning groups. Each group was responsible for answering the following six questions concerning each of their assigned priorities:

1. *What is currently being done to address this priority?*
2. *Who is doing the above?*
3. *If nobody, who could assume leadership/responsibility for addressing this priority?*
4. *Sources and types of resources necessary to address the priority?*
5. *Obstacles to the implementation of this priority?*
6. *Actions*

The information concerning the top five program priorities is followed by that concerning the top five research priorities.

Program Priorities

The top five program priorities identified by the conference participants were:

1. *Creation of an Office of Rural Health within the State system, to more directly address problems of health care in rural areas. The functions of this office might include taking an active part in planning, developing, and administering funded primary care projects, with an eye toward involvement of all agencies and individuals with an interest in rural health. Also, this office should have the responsibility to consider the entire arena of health care in rural areas, with a concern for all of the health care needs of all of the residents, weighed against existing health care resources.*
2. *Legislative changes to enable non-medical health professionals to provide primary care services on a more independent basis.*

3. *Increase the supply of health personnel to rural areas, particularly physicians and nurse practitioners.*

4. *Expand the legal functions of nurse practitioners in rural health (centers), with the Board of Nurse Examiners to take a more aggressive role in making advanced nurse practitioners services more available, more recognized, and reimburseable.*

5. *Develop a statewide system of reimbursement to institutions for the care of the medically indigent.*

Both planning Groups I and II discussed priority one. Planning Group I was also responsible for priorities three and five, while Planning Group II dealt with priorities two and four. The following is a summary of the results of the planning groups discussion for each priority one through five.

1. *Creation of an Office of Rural Health within the State system, to more directly address problems of health care in rural areas. The functions of this office might include taking an active part in planning, developing, and administering funded primary care projects, with an eye toward involvement of all agencies and individuals with an interest in rural health. Also, this office should have the responsibility to consider the entire arena of health care in rural areas, with a concern for all of the health care needs of all of the residents, weighed against existing health care resources.*

Four states which presently have an Office of Rural Health are: North Carolina, Arkansas, Michigan and Virginia. It was agreed that the functions listed in the priority need to be addressed in Texas. The conference participants, however, did not agree on whether a separate State Office should be created to handle the problems of health care in rural areas. One concern was that the creation of another component in the state bureaucracy would create more problems rather than solve them. An Office of Rural Health could be caught between the public and private sectors. It was concluded that a coalition of existing organizations would be a more effective mechanism for focusing attention on rural health issues.

The State Health Department, Texas Department of Community Affairs and Health System Agencies were identified as organizations which could be responsible for addressing this priority. The difficulty is that none of these agencies has a clear mandate for addressing the concerns expressed in the priority. For example, the delivery of primary care to rural Texas is not a function of the Texas State Health Department.

The Texas Rural Health Field Services Program was identified as the organization presently attempting to carry out several of the activities of this office. (See Appendix F) Although the Program does not fund primary care projects, the Program staff assists with the planning and development of these projects. It was suggested that the Program could function as a clearinghouse or a focal point for addressing some of the needs contained in the priority, such as developing a coalition or network of rural health agencies, groups and individuals.

The primary obstacles to the implementation of this priority are:

1) Lack of concern about health problems and health care delivery in rural areas by urban Texans, State Agencies, the Texas Legislature, and the Governor.
2) Lack of funding; and
3) Lack of personnel.

The suggestion was made that the Texas Rural Health Field Services Program seek funding to implement the suggested solution. It could take responsiblity for both investigation of the need, and if necessary, the creation of such an office or coalition. The staff could review present services and apply for funding to research if such an office was feasible. In addition, the TRHS should establish an advisory committee to identify possible funding sources for an Office of Rural Health.

At the close of the planning session, it was pointed out that before any actions are taken, rural Texans should be asked if they want an Office of Rural Health. Do they feel that this kind of Office, coordinating rural health needs, concerns, and funding, would benefit rural Texans? If yes, then it is time to begin the creation of the Office of Rural Health.

2. *Legislative changes to enable non-medical health professionals to provide primary care services on a more independent basis.*

and

4. *To expand the legal functions of nurse practitioners in rural health (centers), with the Board of Nurse Examiners to take a more aggressive role in making advanced nurse practitioners services more available, more recognized and reimburseable.*

Planning Group II identified their assigned priorities, two and four, as being directly related and discussed them together. The results of this discussion are reported here.

Presently, there is no coordinated approach to legislatively expanding the legal functions of non-medical health professionals. Because of AG Opinion 1295, the issue concerning the legality of delivering health care under standing orders is receiving legislative attention by the Senate Ad Hoc Committee on Standardized Medical Procedures and the House Interim Subcommittee on Nursing Shortage and Standing Orders. Concern was expressed that the Senate and House Committees were receiving input from lobbies rather than communities, rural residents and clinics.

The Board of Medical Examiners (BME), in an attempt to resolve the issue, has promulgated "Standing Delegation Order" rules and regulations. The group said that the BME's rules and regulations limit the role

of non-medical health professionals in delivering primary care rather than expanding their role.

A logical approach to solving the problem would be to amend the Medical and Nurse Practice Acts and the Pharmacy Laws to allow non-medical health professionals to provide primary care on a more independent basis. Nurse Practitioners, physician assistants and paramedics were identified as the three groups needing immediate legislative authority to deliver primary care in rural areas. It was decided that obtaining this authority should be a priority item for the 1981 legislative session.

Possible methods for implementing the priorities discussed were:

1. A coalition of non-medical health professional individuals, groups and associations.
2. Examination of what other states are doing - for instance New Mexico uses telemetry to provide communication between physician assistants in rural areas and physicians in urban areas.
3. A study of the cost-effectiveness of utilizing nurse practitioners and physician assi[illegible]ts in the delivery of primary care in rural areas.

Leadership for addressing this priority should be assumed by the coalition of non-medical health professionals, with the support of rural residents and communities. It was emphasized that a large number of people and g[illegible]oups involved in the coalition is the key to initiating legislative change.

The group identified a number of obstac[illegible] the implementation of these priorities. The primary barrier is the Texas Medical Association's opposition to "allowing other individuals to practice medicine."

Other obstacles include: physician's concern with a loss of income, and a surplus of physicians projected for 1983 in Texas. Studies have shown that allowing nurse practitioners to deliver primary care on an independent basis has not decreased a physician's income, but in many cases, has increased it. Additionally, nurse practitioners and physician assistants frequently provide services to those rural residents a physician is reluctant to see, i.e., the poor. A surplus of physicians in other states, such as California, has increased accessibility to health care for urban residents. In no state has a surplus of physicians improved accessibility to health care for rural residents.

The group concluded that it may take more than one legislative session to pass the changes necessary to expand the legal functions of non-medical health professionals.

3. *Increase supply of health personnel to rural areas, particularly physicians and nurse practitioners.*

Several groups and organizations were identified who are currently addressing the problem of the supply of physicians to rural areas, for example:

The Medical Schools in Texas;

The TMA placement program;

The National Health Service Corps;

The Primary Care Residency Program; and

Local Chambers of Commerce.

The Texas Rural Medical Education Board "forgives" loans made to medical students who practice in rural areas. Also, there are private agencies which place health professionals in rural areas for a fee. One problem is the apparent competition rather than coordination between these groups.

Concern was expressed that little or no attention was being directed at increasing the supply of nurse practitioners to rural areas. Nurse practitioner programs in Texas are decreasing in number and are not state supported as are medical schools.

The group stated that the major problem was not the supply of health professionals, but the distribution of these individuals. Most health professionals tend to locate in urban, rather than rural areas. Among the suggestions for improving this situation were 1) a better matching service for health professionals interested in rural areas, 2) encouraging communities to sponsor "locals" to attend medical or other health professional schools who intend on returning to their home town to practice and 3) an orientation aimed at reducing culture shock for health professionals wanting to practice in rural areas.

Another approach to the problem of maldistribution of health professionals in rural areas would be to contract for part time medical services vs. live-in health professionals, on an hourly wage vs. a fee for service basis. Some of the problems of recruiting health professionals deal with cultural and entertainment deficits in rural areas. Another commonly registered complaint is the lack of exposure to other professionals. This could be resolved through providing extensive training and an educational leave program for local rural health professionals.

One approach to solving the supply problem would be to legally increase the functions of health professionals, rather than increasing the number of health professionals. For example, nurse practitioners need legal restrictions lifted to allow them greater flexibility in delivering primary care to rural Texans. Third party reimbursement

for non MD health providers was suggested as the fastest way of solving the problem.

5. *Develop statewide system of reimbursement to institutions for care of the medically indigent.*

Medicaid, Hill-Burton and Medicare programs are attempting to meet this need, but there is one basic problem. A clear definition of Texas' medically indigent is needed. The Texas Department of Human Resources, Commissioners courts, County Hospitals, and hospitals using Hill-Burton funds are all responsible, to varying degrees, for meeting the health needs of the medically indigent. However, there is no coordinated effort being made to meet their needs. Texas Legal Aid is attempting to enforce the statutory obligation of counties to provide health care for the medically indigent, however, this effort is not being coordinated on a statewide basis.

Reimbursement under existing federal programs complicates the delivery of health care to the medically indigent. The National Institute of Mental Health uses a formula which penalizes rural programs in terms of reimbursement. Under Medicare and Medicaid, rural physicians are reimbursed at lower rates than urban physicians. Generally, rural and small hospitals and teaching hospitals are hardest hit in terms of funds lost through ineffective reimbursement.

Suggested solutions include 1) documenting the enormity of the problem of the medically indigent, 2) insuring hospitals against losses incurred when they treat medically needy individuals and 3) developing HMO-like structures for rural areas.

Research Priorities

The top five research priorities identified by the conference participants were:

1. *Research on unmet need, i.e., types of people who are underserved, geographical location - develop conceptually and empirically sound index of medical underservice.*

   Research on demand - i.e., consumer-produced vs. provider-produced

   Research on supply - i.e., descriptive (what's out there?) and analytic (why is it that way?)

2. *What health problems, if any, are unique to residents in rural areas of Texas? What health problems are not prevalent in rural areas?*

3. *Study of health services in each county and determination of duplication, competition or other problems (as between state and federal programs.)*

4. *Descriptive study - present status of rural health efforts in Texas - possibly focusing on initiatives existent in HSA plans, and state plans. The identification of overlap/duplication of effort between voluntary and governmental groups with the interest of better collaborative planning.*

5. *Comparative case studies of community development efforts which identify barriers, change processes, actors, etc. and which focus on innovative community problem solving. These should be carefully disseminated to community leaders, health planning staffs, and legislative staffs.*

Planning Group I discussed priority one and Planning Group II, priority two. The following is a summarization of these discussions.

1. *Research on unmet need, i.e., types of people who are underserved, geographical location - develop conceptually and empirically sound index of medical underservice.*

   Research on demand - i.e., consumer-produced vs. provider-produced

   Research on supply - i.e., descriptive (what's out there?) and analytic (why is it that way?)

   There are numerous groups currently collecting data which addresses the problem of unmet needs, but there has been no effort to coordinate

this data collection. For example, the Texas State Health Department collects morbidity data, the Department of Human Resources collects Medicaid eligible figures, Health Systems Agencies consolidate a variety of secondary data and numerous other smaller organizations and agencies collect bits and pieces of this overall data set.

The fundamental problem is that the data which are available are on the population served, not the population unserved. The 1980 census may be somewhat useful in providing the basis for developing projections of needs and utilization but there is no one agency or organization responsible for conducting those updates. One problem with most of the data described above is that of timeliness. For example, data available through the Health Systems Agencies is often two to four years old at the time of collection. Organizations or groups which could be involved in helping to address this priority are the Texas Research League and the National Rural Center.

The most agreed upon suggestion was a coalition of the major universities in the state. Through this coalition the following three approaches would be implemented: 1) conduct a survey in Texas similar to the National Health Interview Survey, 2) expand the case study approach used in numerous utilizations surveys to include several (and a variety) of rural Texas towns and 3) coordinate existing local resources and data through some kind of cooperative network.

Among the elements to be considered in the development of a university research coalition were the combining of research and the training of indigenous health aids to function as data collectors, and later, as community health aides. The importance of an interdisciplinary planning team to design and conduct the survey also was

stressed. Standardization of measures and indices for utilization of health services were identified as a key activity of this group.

A number of the participants stated that funds were available especially if pieced together from public and private sources. Specifically the Texas State Legislature was suggested as a vehicle for promoting this research. Among possible sources identified were the TDCH, Hogg Foundation, National Science Foundation, and the Texas Department of Human Resources.

It was suggested that a coalition of agencies and groups, could be put together to politically force the issue. Two of the medical schools in the state are committed to rural health on paper through their mandate. The legislature could pressure them to comply with that mandate not only by educating health professionals, but also by conducting research on rural health problems.

There is an obvious need for some type of clearinghouse for funding as well as a means of recording research being done. The Texas Rural Health Field Services Program was agreed upon as the group which could facilitate the initiation of such a project. This coordination could come in the form of networking: that is, putting people with similar interests in touch with each other, identifying sources of funds, and/or coordinating a lobbying effort with both the universities and legislature to push for such a piece of research.

2. *What health problems, if any, are unique to residents in rural areas of Texas? What health problems are not prevalent in rural areas?*

While no one is doing long term or systematic study of the health problems of rural residents, various groups and agencies collect data dealing with rural Texas. For example, the Farm Bureau collects

accident data, the lumber industry collects health data concerning its workers, federal health projects collect health data on the populations they serve and the health department collects statistics on mortality and morbidity. All of this existing data is inadequate and incomplete for determining the uniqueness and prevalence of Texas' rural health problems.

Concern was expressed regarding:

1) the inaccuracy of present health data;
2) the inability of researchers and planners to compare data due to different data collection methods;
3) unreported data and the use of unreliable data indices;
4) the reluctance of agencies and groups to share their data with others; and
5) the age of available data.

It was suggested the first step should be an examination and documentation of existing data. This should include who has what data, in what form, what are the problems with this data, where is duplication of data collection going on, and who is doing what studies on rural health problems in Texas. It was decided that this study could be coordinated by the School of Public Health, Texas Rural Health Field Services Program, Texas A & M University, or similar groups.

The study of rural health problems consists of more than one research project. In addition to examining the health and services problems of rural Texans, the study needs to explore: 1) financing of health care in rural Texas 2) definition of "rural", 3) differences in rural vs. urban practice of various health professionals and 4) uniqueness of health problems of rural Texans. The study, especially in terms of the uniqueness of health problems, needs to be conducted over

over a period of time.

A consortium of individuals and academic institutions is needed to carry out the priority. The group decided the next step is to meet with other interested individuals for the purpose of designing a conceptual framework for the study. The framework would provide an organizing structure for those engaged in rural health research. The Texas Rural Health Field Services Program should host this meeting.

The major obstacles to conducting the research were time, money and committment. Due to the emphasis placed on researchers by academic and funding institutions to "publish or perish", another obstacle could be one of "turf", or possessiveness concerning data collected. The group decided that this obstacle could be overcome if everyone was working toward the same goal. Upon adjournment, some of the group's members made a committment to meet in the fall to develop the conceptual framework.

Conclusion

Planning Group I and II both felt that future meetings to discuss research priorities three, four and five were needed. The Texas Rural Health Field Services Program agreed to host the meeting in the fall.

CONFERENCE EVALUATION

At the end of the conference, a brief, five question evaluation form (Appendix G) was provided for completion by all participants. The results of these evaluations are provided and analyzed below:

1. *Was this conference a productive use of your time?*

71%	19%	1%
Yes	Undecided	No

2. *Do you feel the process used today was an effective way of identifying research and program priorities for rural health care in Texas?*

38%	19%	29%	14%
Yes		Undecided	No

Thirty-eight percent definitely felt that the modified nominal group process was effective. Another 19% were not so sure of the process' effectiveness, but leaned more toward yes than undecided. Twenty-nine percent of those who responded were undecided about the effectiveness of the process. Fourteen percent definitely felt that the process used was not an effective way of identifying research and program priorities. Several respondents felt the process improved as the conference continued.

3. *What did you like most about today's conference?*

Fifty-seven percent of those completing the evaluation felt the exchange of knowledge and the opportunity to interact with professionals who have a wide variety of expertise and opinions were the most favorable aspects of this conference. Another large percentage,

approximately 32%, stated that the small group concept utilized throughout the conference increased communication between those attending and further encouraged their participation. The remaining evaluations showed appreciation for the organization and structure of the conference and appreciation for the emphasis given to developing a statewide network for rural health concerns.

4. *What did you like the least about today's conference?*

Eighty-five percent of those completing the evaluation form said that the survey responses should have been catagorized and further collapsed before the conference date.

Another 15% indicated that health education was not dealt with, and that there was little time alloted to become better acquainted with others in attendance.

5. *Other comments or reactions?*

Sixty percent of those completing this section of the evaluation form wrote that the conference was indicative of hard work and that the Texas Rural Health Field Services Program should continue with such efforts.

Another 20% commented that spin-offs to and follow ups of this conference would tell the true story of the conference's effectiveness.

CONCLUSION AND FUTURE DIRECTIONS

This conference entitled "Texas Rural Health Program and Research Priorities for the 1980's", accomplished its initial goal of identifying and prioritizing the five most important areas for both future programs and research in the health care of rural Texas. This conference began the process of communication and cooperation between individuals and groups interested in Texas rural health care. Accomplished during this conference was the specification of action plans for each of the five program priorities and for two of the research priorities.

Two themes repeated themselves throughout the conference. They are, one, the Texas Rural Health Field Services Program is the only office in the state which is currently addressing many of the issues and priorities identified by the conference participants and two, that networking and consortium building will be a key factor in achieving change and improvement in rural health care in Texas.

While a framework for a concerted group effort was introduced with this conference, still more activity is needed in the near future to formalize an organizational structure which will address the needs of rural Texans. TRHS plans to aide this organizational building effort by encouraging networking among individuals and groups interested and involved in health care in rural Texas. This effort was begun with a list of "Persons Interested in Rural Texas." This list will be added to and updated frequently. TRHS plans to further formalize action strategies and implementation plans for the top five program and research priorities by hosting two meetings in the Fall of 1980. The next step would be a statewide conference to put these

strategies and implementation plans into action.

For change to occur, the next ten years should be devoted to utilizing and sharing the knowledge of rural health care which is or can be made available. Cooperation and communication between professional planners, researchers, health providers, rural residents, communities and groups, state agencies, universities, policy makers and funding sources can insure that more adequate health services will be made available to rural Texans. It is important that the program and research priorities identified by the conference participants become priorities in the minds of local, state and federal policy makers, funding sources and everyone concerned about and involved in health care delivery in rural Texas. We have ten years in which to work for a healthier rural Texas. Let us work together to make the 1980's the decade that will make a difference.

Appendix A

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page 24. Blank

28

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*Participants are defined as those individuals who sent in their survey form and/or attended the conference.

Appendix B

"Invitational Letter and Survey"

THE UNIVERSITY OF TEXAS AT AUSTIN
SCHOOL OF NURSING
AUSTIN, TEXAS 78701

Texas Rural Health Field Services Program
1700 Red River
512—471-7311

Good Morning!

You are cordially invited to attend a conference/workshop on Texas Rural Health Issues for the 1980's. The conference has been scheduled for Friday, April 18, 1980 from 10:00 a.m. to 4:00 p.m. at the U.T. School of Nursing, 1700 Red River, Austin. The purpose of this conference is to bring together a small, select group of individuals with expertise in rural health issues to discuss and identify directions for future research and program activities.

Further elaboration or repetition of issues and problems in Texas rural health care is not the purpose of this conference. The problems in rural Texas health care have remained much the same for decades, among those are:

1. Limited access to health services, particularly primary care services.

2. Lack of health manpower - not only primary physicians, but also nurse practitioners, psychologists, social workers, pharmacists, dentists and others.

3. Limited availability of health services such as emergency and preventive services.

4. Laws, regulations and practices which place constaints upon the development of innovative solutions to rural health problems.

5. Lack of a coherent state health policy and rural health policy.

Rather than belabor the point that these issues exist and are affecting the lives of rural residents, the goal of this conference is to develop a plan of action for research and program activities aimed at resolving these issues in the 1980's.

The specific objectives of this conference are to:

1. Identify and prioritize the top research and program activities for Texas rural health care in the 1980's.

2. Develop networks of communication and cooperation between individuals and groups with complimentary interests related to Texas rural health.

page 31 - Blank

Your input to the planning of this conference is sought through the brief survey form we have enclosed with this letter. At the end of this survey, you will find a reservation and information form on which you can tell us more about you and your interests.

If you do not plan to attend the conference, we would still like you to complete the survey and the information form. If you do plan to attend the conference, you can expect another letter from us in early April summarizing the responses to this survey.

Follow the survey directions carefully and return your survey and information form by

For many years, we have talked about the need to change the health care delivery systems of rural Texas. As of yet, no real changes have been realized and many of the same long-standing problems and concerns continue. Let 1980 be the decade that will make a difference, join us on April 18 at the conference "Texas Rural Health Issues for the 1980's".

Sincerely yours,

Mary

Mary Walker, R.N., Ph.D.
Program Director
Texas Rural Health Field
Services Program

Jim

Jim Burdine, Dr. P.H.
Coordinator of Community
Health Education
U.T. Austin
Department of Physical and
Health Education

Enclosures

Texas Rural Health Issues of the 1980's: A Survey

of Research and Program Needs

Please complete and return this survey form in the accompanying self-addressed stamped envelope by

Specifically list what you consider <u>should</u> be the top five priorities in research and programs for Texas rural health care in the 1980's. Define the research or program needs as clearly as possible (in more than categorical terms). Be as specific as possible when particular populations or geographical areas are involved. An example of the kind of response we are seeking is: "a survey of mental health needs and status of minority populations in rural areas of south Texas."

Research Priorities for Texas Rural Health in the 1980's:

1.

2.

3.

(Over)

Research Continued:

4.

5.

Program Priorities for Texas Rural Health in the 1980's:

1.

2.

3.

4.

5.

Please complete the following information:

Your name: _____

Title: _____

Organization/Agency: _____

Address: _____

_____

Telephone number(s): _____

Plan to attend "Texas Rural Health Issues in the 1980's Conference":

Yes _____ No _____

What are your areas of expertise and interest?

(Over)

Please include a brief description or a copy of any research projects or program evaluations you have done in the area of rural health. If there are bibliographies or papers that you feel would be helpful to other participants, please include them with your survey response.

Thank you very much for your cooperation.

Appendix C

"Program Priorities for Texas Rural Health for the 1980's"

"Small Group Voting Ballot"

"Program Planning Worksheet"

Program Priorities for Texas Rural Health
for the 1980's

1. Creation of an Office of Rural Health within the State system, to more directly address problems of health care in rural areas. This might include taking an active part in planning, developing, and administering funded primary care projects, with an eye toward involvement of all agencies and individuals with an interest in rural health. Such an office should have a responsibility to consider the entire arena of health care in rural areas, with a concern for all of the health care needs of all of the residents, weighed against existing health care resources.

2. Focus more on hypertension screening and treatment programs, especially relating them to nutritional and environmental factors.

3. Develop <u>educational programs</u> on several different levels - primary/secondary schools, extension services, continuing education programs for health manpower, etc.

4. Develop a school based health education (promotion) program for grades K-12 students. This should be a community health education program based in the schools.

5. Develop an educational program designed to communicate appropriate usage of health services and resources available. Use the school based health education programs as the communication avenue.

6. Health education (more extensive and comprehensive) for youth. In and out of school setting.

7. Development of a health policy which is more than rhetoric . . . Careful examination of concepts involved plus development of precise measures for these concepts . . . a policy that would lend itself to implementation and evaluation.

8. Explicit legislative policy statements detailing urban and rural program objectives in new legislation.

9. Development of a state rural policy including population, economic and social services.

10. Identification of funding sources not only for research in the area of rural health, but also for development of innovative programs for health care delivery, educational programs, etc.

11. Establish a "clearinghouse" for research in the area of rural health. Responsible for dissemination of research findings to both interested researchers and communities. Could play active political role at local and state level.

12. Focal point for information and analysis of legislative issues pertaining to health in Texas.

13. Collaboration of agencies, programs, universities, etc. for health resource/research network.

14. Involvement of rural youth in health field - education and job opportunities.

15. Developing and facilitating interdisciplinary health professions training in non-traditional rural sites i.e., team projects on community assessment, providing care, etc. for groups including health educators, social workers, plus varieties of medical, nursing and other allied health students.

16. Legislative changes to enable non-medical health professionals to provide primary care services on a more independent basis.

17. A health manpower program providing for required practice in rural areas should be enacted.

18. Increase supply of health personnel to rural areas, particularly physicians and use of nurse practitioners.

19. Increase the numbers of physicians and dentists in rural areas.

20. Develop collaborative network with voluntary health agencies to increase their involvement in rural areas.

21. Increase family planning services in rural areas.

22. Problems of teenage pregnancies.

23. Work closely with other rural development efforts aimed at improving total rural economy and setting, i.e. housing, transportation, etc.

24. A comprehensive health care plan for the state should be developed. While the state planning agency has a plan, I do not feel that it adequately adheres the issue of rural health.

25. Funding of a non-categorial medicaid program.

26. Establishment of comprehensive "health home" for each indigent or "medical needy" family in centrally located facility.

27. Crisis stabilization services in the least restrictive setting possible, with hospitalization available when other options are insufficient.

28. Transportation of clients to services. The transportation would be client oriented rather than program oriented.

29. Case management, to ensure continuous availability of appropriate forms of assistance.

30. Quality medical and mental health care.

31. Stricter accountability among state agencies in the service allocation mechanisms used by state agencies providing services to rural counties.

32. Establishment of an information system to monitor changing indicators of health status and access to care e.g., annual surveys similar to the National Health Interview Survey.

33. Consumer's role in health planning: What it is; how it affects rural Texans; how to operate effectively within it.

34. Effect of life-style choices in health.

35. Women and smoking.

36. Work-related cancer -- occupational risk factors.

37. Increase public education in emergency first aid procedures and public awareness of the benefits of preventive medicine.

38. Continue current federal and state programs and encourage new program funding where voids exist to increase the scope of telemetry and communication--equip ambulances with trained staff to provide medical attention to patients on-site and while in transit.

39. Development of emergency medical services with transportation equipment for each rural county.

40. Earmark increased funds as provided by the Health Maintenance Organization Act for rural areas.

41. Development of communication/referral process for services that cannot be provided in the medical home.

42. Delete duplication of similar or identical services.

43. Compile published self-care materials and develop self-care teaching methodologies.

44. Survey and price technologies for remote consultation or medical advice, such as Tel-Med or 800 numbers to medical facilities with 24-hour physician coverage.

45. Develop health education component to all rural health projects in state.

46. Better integrations of existing health resources to form regional health care systems.

47. Increasing accessibility of underserved populations. (Financing)

48. Health care for the aged.

49. Development of data management systems in Maternal and Child Health for:

    a. referral of patients

    b. patient transports

    c. patient outcome measures

50. Initiate "health fairs" in rural communities. Establish a central administrative office to coordinate such activities on a regular basis. Include health questionnaires, blood pressure, blood tests, dental screening, self-care literature, etc. Involve local physicians and health manpower in program.

51. Focus more on family planning, prenatal counseling and post-partum care of the rural health population, especially the minority group.

52. For the rural health clinics to have a more cooperative arrangement with local health department offices and school districts in obtaining essential health documents, i.e. immunization records, allergy records, etc.

53. To increase the number of diabetic teaching programs, focusing on the nutritional and dietary needs of the population, especially minority groups.

54. To expand the legal functions of nurse practitioners in the rural health centers, with the Board of Nurse Examiners to take a more aggressive role in making advanced nurse practitioners services more available, more recognized, and reimburseable.

55. Minimize duplication of medical/surgical facilities for rural populations through the use of regionalization of tertiary facilities capable of providing consultation, incremental treatment, and outreach support.

56. Maximize the use of screening tools for health care providers in the rural setting to identify mother at high risk, thereby reducing infant mortality through deliveries of high risk infants at tertiary facilities.

57. Screening services, especially in areas of heart disease, stroke, COPD, and congenital abnormalities.

58. Staff training (MD, RN, etc.) regarding care of ill neonates.

59. Home follow-up and teaching i.e., use of respiratory therapy equipment in the home.

60. Outreach facilities (or mobile vans) to provide outpatient services, i.e., primary care, education.

61. Develop statewide system of reimbursement to institutions for care of the medically indigent.

62. Decrease number of state and federal regulations which escalate cost of health care delivery.

63. Encourage efficient function of rural hospitals with effective transfer linkages.

64. Develop mechanisms to encourage rural area practice.

Priority (highest to lowest)	Item Number
1.	____
2.	____
3.	____
4.	____
5.	____

Program/Research Priority _____ Group _____

Questions to be answered:

1. What is currently being done to address this priority?

2. Who is doing the above?

3. If nobody, who could assume leadership/responsibility for addressing this priority?

Program/Research Priority (con't.) _____ Group ___

4. Sources and types of resources necessary to address the priority?

5. Obstacles to the implementation of this priority?

6. Actions

Appendix D

"Research Priorities for Texas Rural Health for the 1980's"

"Research Small Group Voting Ballot"

"Research Planning Worksheet"

Research Priorities for Texas Rural Health
for the 1980's

1. Evaluate the feasibility of "health promoter" within the family structure - the family is the primary health care provider and should be focused on in exploring the private sector of health care delivery. Include analysis of children as health educators, homemakers as primary health care providers, self-cure programs, and the like.

2. Research on unmet need, i.e. types of people who are underserved, geographical location - develop conceptually & empirically sound index of medical underservice.
   Research on demand - i.e., consumer-produced vs. provider-produced
   Research on supply - i.e., descriptive (what's out there?) and analytic (why is it that way?)

3. Evaluate innovative methods of health care delivery - esp. usage of telecommunications. Feasibility study to look at microwave unit of TAMU College of Medicine and possible remote delivery of health care to Brazos Valley area.

4. Evaluate study of physician location and specially focus on M.D.s in rural areas - personal interviews and site visits - analyze measures of quality of life for M.D. and quality of care to be delivered.

5. Survey of physician extenders (P.A.'s, N.P.'s, etc.) evaluating what they do at this time, what they could do if Texas laws were more liberal regarding their utilization, what they see as primary clients' needs, etc.

6. Task (analysis, inventories) of selected health manpower groups (nurses, EMT's, PA's, etc.) in both urban and rural settings . . . leading to a better understanding of manpower utilization needs in differing settings.

7. Overviewing the concept of health maintenance and developing a comprehensive model of "health" applicable to rural areas. Conceptualize psycho-social-somatic health (or well-being) in terms of environment, behavior, or lifestyle, health care services available, and genetics/heredity.

8. Survey of certified "rural health clinics" in Texas and effect of P.L. 95-210 on these centers (will they apply for recertification).

9. Survey of Technical Assistnace needs at rural health centers. (Financing management, BRD training, medical manpower needs, clinic management.)

10. Health care utilization patterns of Hispanic migrant workers - health care of the undocumented worker - policy and legal issues.

11. A study of the patterns of health provider usage in each region to provide knowledge about where people go for health care. This should include traditional and non-traditional providers.

12. Impact of health education programs on rural Texans.

13. Delivery of mental health services to Latino community.

14. Treatment of Nursing Home Patients - Medicaid/non-Medicaid

15. Trends indicate that the elderly populace will increase 20% during the next decade. Evaluate the scope and accessibility of primary care servcies to elderly people.

16. Thorough assessment of the significance of the elderly in rural areas, as an indicator of critical need for improved services. Many parts of rural Texas have become retirement areas, and this factor may deserve a good deal more attention than it is getting.

17. Survey of health needs of minority elderly in East Texas. This would include subsidary needs such as transportation, nutritional information, etc.

18. Health care for the aged. Extent of problem, location, availability of services, accessibility to service and utilization.

19. Review of the current standards used for involuntary committment in mental institutions.

20. Availability of on-the-scene first aid and transport to hospital (ambulances, Medic cars.)

21. To what extent are emergency care needs in rural Texas being met?

22. The effectiveness of the EPSDT Program in rural areas. Is this program providing adequate screening and care to AFDC children?

23. County's obligation to provide medical care to indigent residents.

24. Medically needy program in Texas. Medicaid for the low income people who do not receive AFDC or SSI.

25. Comparative case studies of community development efforts which identify barriers, change processes, actors, etc. and which focus on innovative community problem solving. These should be carefully disseminated to community leaders, health planning staffs, legislative staffs.

26. Descriptive study - of present status of rural health efforts in Texas - possible focusing on initiatives existent in HSA plans, state plans' and also identifying overlap/duplication of effort between voluntary and governmental groups with intent of better collaborative planning.

27. Continuing study on the use of protocols and standing orders.

28. Examine societal and individual determinants of medical care utilization in rural areas (as contribution to a framework for policy decisions.)

29. Rural health needs in Texas differ from region to region. An attempt should be made to divide the state based on demographic characteristics. Health and illness characteristics in each region should be defined. Use standard indices.

30. Collection of data on Health Status Indicators for each county (rural) and by HSA. Including infants, children, adolescents and adults. Also morbidity data is desparately needed to support programming.

31. Assessment of health resources available to each region should be made. This should include people, places, in both public and private sector of health care.

32. Study of health services in each county and determination of duplication, competition or other problems (as between state and federal programs). This is our greatest problem: Example - Harlingen has the Public Health Regional Office and an active local health Department and a Federally funded health clinic, Su Clinica.

33. Assessment of school health content in each region. Included should be number of hours of instruction, educational background of the teachers of health, textbooks used, % of students receiving health information, and scope of the health content.

34. Health profile of school age children in the region should address nutritional habits and status, health self-image, family health environment, health potential of each student.

35. The number of persons below poverty level who due to Texas restrictive categoral Medicaid program lack resources for health care. The projected cost of implementing such a program.

36. An updated determination of the actual numbers and impact of migrant and seasonal farm workers in rural areas of Texas. The last survey was done by the Governor's Office of Migrant Affairs (GOMA) in 1976, and has some glaring inaccuracies.

37. The actual number of migrant/agricultural workers in Texas by county.

38. What is an appropriate approach to assisting communities identify their real health care needs and to attract necessary health professionals to meet those needs?

39. What is the appropriate role in Texas of the Federal, State, County and City governments in providing health care for indigent patients? How do we achieve a decision as to these roles?

40. The funding of hospitals by the State to take care of indigent health care to alleviate the local funding problems for the hospital and patients.

41. What are appropriate and feasible incentives to encourage physicians, nurses and others to practice in rural areas?

42. Identifiy networks of communication already in place in rural areas related to health and mental health issues.

43. Distribution of mortality and morbidity by area and alternative approaches to probability/testing it.

44. Population shifts in the 1980's -- developing an accurate picture of rural Texas. Including social, health and economic indicators on a county basis. Much of this is census related and will be available in 1982-83.

45. What will be the demography of rural Texas in the next ten or twenty years and what are the implications of that for health care needs?

46. Relationships between education and/or income in rural levels of health care.

47. Is inflation affecting health care practices of middle and lower income groups in rural areas? If so, in what way?

48. Effectiveness of paramedical primary health care providers on patient outcomes in rural settings.

49. Health status of rural Texans under varying access conditions. Is health status actually different (worse) where access to medical care is more limited?

50. Documentation of changing status and access conditions in rural areas.

51. Documentation of urban-rural differentials (if any) in status and access.

52. Survey of knowledge of rural Texans, by ethnic group breakdown, about health planning--what is it; what is their role as a consumer; to whom and how can they make their opinions known.

53. Do health education efforts aimed at rural youth audiences have carry-over educational effects to parents? What effects? By ethnic breakdown?

54. Compare effectiveness of mass media health education channels vs. non-mass media channels (individual contact, group programs) in knowledge gain and behavioral changes to white, Black and Hispanic rural Texans.

55. Evaluate the data collection and other input procedures utilized by the Texas Health Facilities Commission to conduct an "appropriateness review" of proposed health care facilities and services to determine that significant consideration is given to the needs of rural Texas.

56. Impact of Rural Health Initiatives (RHI's) and other grant programs on private health care services; as manpower. There is a complaint that RHI physicians are competing with the private sector physicians.

57. Recruitment of health manpower to insure continuity of care.

58. Establishment of priorities for health systems to address the health status of each rural county.

59. What health problems, if any, are unique to residents in rural areas of Texas? What health problems are not prevalent in rural areas?

60. What is reasonable plan of care for rural residents of Texas in terms of cultural factors and geographic isolation?

61. What are the indicators for the need for professional medical care? What symptoms require professional judgment? Can the problem of lack of care be greatly alleviated by pre-packaged health education materials and self-care materials related to common personal health problems?

62. What are the expectations of health care among rural residents of Texas? What kinds of health care programs do rural Texans want?

63. What types of health care programs or services are rural Texans willing to pay for?

64. New major effort to establish health education through Region 8. This effort should be focused upon public and individual health issues and should work through public schools, adult education programs, and public and private health organizations. It should emphasize prevention of illness and center the responsibility for illness on the individual.

65. A coordinated network of primary health care provides including the public, community, migrant, rural and private clinics should be established in Region 8. There should be incentives for cooperation and working together to serve the entire population of South Texas.

66. Existing specialty and subspecialty diagnostic and evaluation services for children and adults health problems should be made accessable throughout Region 8 by using physician (specialist) extenders working under protocols of specialists and subspecialists practicing in the Region.

67. Development of realistic means of Mexico/U.S. cooperation and shared responsibility with regard to health care of residents of border communities.

68. Study of methods by which groups of rural residents of a given community who differ ethnically, socio-economically, politically, etc., might cooperatively seek solutions to the problem of inadequate health care. Avoid emphasis on competition and differences between people, which only leads to further polarization.

69. Broad survey of health-related needs of selected mid-size town in Texas. By mid-size, I mean between 20,000 - 50,000. This would typically be a town where much of the health care is done at the nearest city (John Sealy, Ben Taub, Brackenridge, Parkland, etc.) and where there is no primary health care clinic.

70. Designing alternative health care delivery models for rural areas of East Texas.

71. Survey of providers and clients of mental health needs in selected target areas of rural South and East Texas.

72. Baseline data of present practices in seeking health care, knowledge, attitudes and reported behaviors of health consumers.

73. Develop and test options for health care delivery.

74. Develop and test programs designed toward actions people can take themselves in prevention and primary care.

75. A regionalized approach to the delivery of comprehensive primary health care services to rural underserved areas. Study of regional system design.

76. Delivery of specialty care to rural areas which is cost-effective. What kinds of specialty care are presently available in the rural areas and the accessibility question.

77. Survey of existing federal health resources in Texas and how they can be better coordinated and integrated with state and local health resources.

78. Continued monitoring of physician distribution in Texas, to see if the problem of maldistribution is being overcome by increased doctor supply.

79. Hospital Based Rehabilitation Program in Rural Areas.

80. The responsibility of local governmental units (counties, cities, etc.) to provide medical care for indigents.

81. Problems in delivery of maternity and child health services in rural Texas.

82. Survey of unmet perinatal outreach education needs in rural Texas.

83. Identification of number and characteristics of lay midwives conducting deliveries but not reporting births. Description of knowledge and skills of parteras (Mexican lay midwives).

84. Description of costs involved in providing perinatal outreach education to rural areas (e.g., professional consultation and involvement, record keeping, travel to various sites, overhead to provider institution, increased costs/benefits to provider institution as a result of perinatl outreach education.)

85. Some significant effort must be made to organize university-based research in the state; to move the research-universities into a more cooperative and united body on these (i.e. rural) issues. In terms of research, current medical school approaches to cancer research (e.g. specialization and communication) might provide a good model. Increases in research productivity, targeting, and political and policy input would increase.

86. Basic epidemeological data is badly needed. Relatively speaking, what are the "health costs" to being rural. Who suffers what? How disproportionately? In all health areas. Without such data, political and policy influence is hard to come by, and it is costly to be promoting a program blind.

87. Very tough evaluation of existing rural programs is needed. Right now, given acute shortages, tough decisions must be made on the real productivity (i.e., benefits vs. costs) of existing programs. This applies to all health related, rural targeted programs (e.g. clinics of all kinds, training programs at medical schools, community-based programs, citizens groups, etc.)

88. Value of screening tests for individuals in high-risk categories.

89. Descriptive survey of existing health services and their site of provision and frequency in rural Texas settings.

90. A survey of the number of rural health centers that have an active diabetic teaching program, focusing on the needs of hispanic clients.

91. An analysis of present immunization status among the rural health centers' population and what efforts are being taken to reach a desirable level of immunization.

92. An analysis of the present functions and duties of advanced nurse practitioners and how the functions relate to medical practice (by licensed physicians).

93. To research the need for a regionalized medical/surgical resource center to provide for outreach education of the community hospital staff, tertiary medical/surgical referral and consultation services, and finally, support medical/surgical services to individual clients through a referral and transport program (from the community hospital to the tertiary center, and back to the community hospital for recovery care and discharge).

94. Identification and treatment of high risk mothers utilizing a network of screening tools to minimize delivery of high risk infants at the small community hospital with limited resources. Research is needed to identify demographics, health service capabilities, modes of referral and transport methodologies, communo-adaptive measures to educating both the public and professional sectors, and quantifying cost effective alternatives utilizing programmable morbidity and mortality statistics.

95. Research a systematized reciprocal concept for screening, referral, consultation, incremental support treatment, medium and long term recovery, and discharge with follow-up for all demographic areas. Utilizing a hub-spoke module, population centers would be assigned a tertiary resource facility, secondary treatment centers, and primary screening referral points to provide for the health care needs of rural populations.

96. An analysis of the functions of physician assistants and how they differ from registered nurses and nurse practitioners' functions and duties.

97. A survey of the number of existing Alcohol Treatment Programs in the rural health field and a listing of the programs' objectives and population group.

98. Reimbursement mechanisms for hospital care for the indigent (non-Medicaid) by county governments in Texas.

99. Methods of providing economic and other incentives for physician location in manpower shortage (physician shortage) rural areas.

100. Economic justification for small hospital operation in rural areas (10 tO 50 beds)

- occupancy rates that permit operation in the Black
- cost effectiveness as compared to urban institutions
- real cost of out migration from rural areas for care:
  travel cost for patient and family (hotel, meals, work time lost ect.)

101. Excessive cost of state and federal regulations to the health care delivery system.

Priority (highest to lowest)	Item Number
1.	____
2.	____
3.	____
4.	____
5.	____

71

Program/Research Priority _____ Group _____

Questions to be answered:

1. What is currently being done to address this priority?

2. Who is doing the above?

3. If nobody, who could assume leadership/responsibility for addressing this priority?

NOTES

73

Program/Research Priority (con't.) _____ Group _

4. Sources and types of resources necessary to address the priority?

5. Obstacles to the implementation of this priority?

6. Actions

NOTES

Appendix E

"Facilitator's Packet"

76

Facilitator's Schedule (Program)

Registration . . . . . 10:00 - 10:15

Introduction and Welcome . . . . . 10:15 - 10:30

Small Group Session . . . . . 10:30 - 11:20

Vote on Survey Response 10:30 - 10:50

Top Five Priorities Developed 10:50 - 11:10

Report to Rest of Group . . . . . 11:10 - 11:20

Once the top five have been developed, move your group to the front of the room and write the top 5 on your flipchart. Starting with facilitator A, report your group's findings.

Conference Vote on Priorities . . . . . 11:20 - 11:30

Facilitator A & B (those finished first) will move to the back of the room and write priorities on the board and prepare for the planning group. Facilitator A will write Priorities 1, 3 & 5 on Planning Group 1 board. Facilitator B will write Priorities 1, 2 and 4 on Planning Group 2 board.

Planning Group Session . . . . . 11:30 - 12:30

Three priorities will be discussed, five questions on each will be answered. Suggested time table for this is below:

Planning Group 1		Planning Group 2	
11:30 - 11:50	Priority One	11:30 - 11:50	Priority One
11:50 - 12:10	Priority Three	11:50 - 12:10	Priority Two
12:10 - 12:30	Priority Five	12:10 - 12:30	Priority Four

This means approximately 4 minutes should be spent on each of the five questions.

Lunch . . . . . 12:30 - 1:30

Facilitator's Schedule (Research)

Introduction to Research Group . . . . . 1:30 - 1:35

Small Group Session . . . . . 1:35 - 2:25

Vote on Survey Response 1:35 - 1:55

Top Five Priorities Developed 1:55 - 2:15

Report to Rest of Group . . . . . 2:15 - 2:25

Once the top five have been developed, move your group to the front of the room and write the top 5 on your flipchart. Starting with facilitator A, report your group's findings.

Conference Vote on Research Priorities . . . . . 2:25 - 2:35

Facilitator A & B (those finished first) will move to the back of the room and write priorities on the board and prepare for the planning group. Facilitator A will write Priorities 1, 2 & 4 on Planning Group 1 board. Facilitator B will write Priorities 1, 3 and 5 on Planning Group 2 board.

Planning Group Session . . . . . 2:35 - 3:35

Three priorities will be discussed, five questions on each will be answered. Suggested time table for this is below:

Planning Group 1		Planning Group 2	
2:35 - 2:55	Priority One	2:35 - 2:55	Priority One
2:55 - 3:15	Priority Two	2:55 - 3:15	Priority Three
3:15 - 3:35	Priority Four	3:15 - 3:35	Priority Five

This means approximately 4 minutes should be spent on each of the five questions.

Closing Statements . . . . . 3:35 - 3:45

Evaluation . . . . . 3:45 - 4:00

78

Do's and Don'ts for Facilitators

1. Report to Mary's office at 8:30 a.m. sharp on Friday April 18.

2. Dress neatly and appropriately.

3. Have a watch or time piece of some sort with you.

4. Before beginning each task, explain what the group is expected to do, --- Answer any questions briefly and to the point.

5. Time is of the essence. Try to stick to suggested schedule as much as possible. It will be your responsibility to enforce time limits upon your participants. Be Firm. Hand out the necessary handouts when you feel the task they pertain to should begin, this should provide you with more control over time.

6. When in the initial small groups, don't allow a lot of talking between participants --- in fact don't allow any. On their ranking of priorities (1-5) you want their first reaction.

7. In the larger planning sessions, discussion is necessary. However, you must remember you have only about four minutes to spend with each question.

8. If one step takes less than the suggested time period, you can return to any unanswered questions. Cover as many questions about the three priorities as you can.

Appendix F

"The Texas Rural Health Field Services Program"

THE UNIVERSITY OF TEXAS AT AUSTIN
SCHOOL OF NURSING
AUSTIN, TEXAS 78701

Texas Rural Health Field Services Program
1700 Red River
512—471-7311

THE TEXAS RURAL HEALTH FIELD SERVICES PROGRAM

Texas is a land of contrast. There are densely inhabited urban areas with growing economies, and vast areas of sparse population often with declining social and economic systems. Health resources and services, like any other resources and services, follow people. Where the population is sparse there have also been few or no health professionals, facilities or services.

There is an increased interest among consumers and providers in improving the delivery of health care in these rural areas. Consequently, a stronger need for more information and for individuals knowledgeable in the area of rural health care is being experienced. Pressures for development of federal and state policies addressing rural health care needs are increasing. A unique opportunity exists to impact these policies as they are formulated.

The ability to have an impact will depend on several factors: the development of documented data supporting various approaches to the delivery of health care in rural areas; a program for monitoring state as well as federal policies, regulations and programs from the viewpoint of rural needs; and the formation of a network or people interested in rural health problems to exchange information and to make their views known in a timely and effective fashion.

The TEXAS RURAL HEALTH FIELD SERVICES PROGRAM has been designed to meet this increasing need for information in the rural health area. The program is under the direction of Dr. Mary Walker, R.N., and is supported by grants from the Sid Richardson Foundation, the Moody Foundation and the Meadows Foundation. The Program staff will provide the following services:

1. Help individuals, groups and institutions undertaking rural health projects to locate information, resource people, and funding sources which can assist them in planning, developing and implementing their projects.

2. Provide Texas policy makers with information and recommendations on rural health problems in the state.

3. Provide federal decision-makers with information about rural health problems in Texas.

4. Monitor the development and implementation of state and federal rural health policies and programs.

5. Inform rural Texas residents about state and federal legislation and policies (proposed, as well as, implemented) which affect the delivery of adequate health care to rural people.

6. Serve as a liaison between federal and state health agencies and rural residents and providers.

7. Assist rural health projects within an area to coordinate their activities to avoid duplication in health services.

8. Create a collection of rural health resource material oriented to Texas and located at the University of Texas at Austin School of Nursing.

9. Help organize state/regional seminars and conferences on rural health problems.

10. Identify problems and areas in rural health care which require either research or evaluation and where feasible, develop proposals, obtain funding and conduct these projects. The information gathered would then serve to help identify solutions to rural health problems in Texas.

11. Help organizations, such as the Texas State Health Coalition and the Student Health Coalition, develop viable and effective mechanisms for improving the health of rural Texans.

12. Encourage programs which give students in the health professions and rural residents interested in the health professions the opportunity to become aware of the problems and acquire experience in the delivery of health care in rural areas.

The Texas Rural Health Field Services Program is located at the University of Texas School of Nursing, 1700 Red River, Austin, Texas 78701. Your visit will be welcome - or call us at (512) 471-7311. We are looking forward to hearing from you!

82

Appendix G

"Evaluation Form"

"Texas Rural Health Research and Program
Priorities for the 1980's"

1. Was this conference a productive use of your time?

Yes Undecided No

2. Do you feel the process used today was an effective way of identifying research and program priorities for rural health care in Texas?

Yes Undecided No

3. What did you like the most about today's conference?

4. What did you like the least about today's conference?

5. Other comments or reactions?

84